R590. Insurance, Administration. Effective 5-25-99

R590-191. Unfair Life Insurance Claims Settlement Practices Rule.

R590-191-1. Authority.

This rule is promulgated pursuant to Subsections 31A-2-201(1) and 31A-2-201(3)(a) in which the commissioner is empowered to administer and enforce this title and to make rules to implement the provisions of this title. Further authority to provide for timely payment of claims is provided by Subsection 31A-26-301(1). Matters relating to proof and notice of loss are promulgated pursuant to Section 31A-26-301 and Subsection 31A-21-312(5). Authority to promulgate rules defining unfair claims settlement practices or acts is provided in Subsection 31A-26-303(4). The authority to require a timely response to the Insurance Department is provided by Section 31A-2-204.

R590-191-2. Purpose.

This rule sets forth minimum standards for the investigation and disposition of life insurance claims arising under policies or certificates issued to residents of the State of Utah. These standards include fair and rapid settlement of claims, protecting claimants under insurance policies from unfair claims settlement practices and promoting the professional competence of those engaged in processing claims. The various provisions of this rule are intended to define procedures and practices which constitute unfair claim settlement practices. This rule is regulatory in nature and is not intended to create a private right of action.

R590-191-3. Definitions.

For the purpose of this rule the Commissioner adopts the definitions as set forth in Section 31A-1-301, and the following:

(1) "Beneficiary" means the party entitled to receive the proceeds or benefits occurring under the policy.

(2) "Claim File" means any record either in its original form or as recorded by any process which can accurately and reliably reproduce the original material regarding the claim, its investigation, adjustment and settlement.

(3) "Claim Representative" means any individual, corporation, association, organization, partnership, or other legal entity authorized to represent an insurer with respect to a claim.

(4) "Claimant" means a person making a claim under a policy, including an insured, policyholder, beneficiary, or the claimant's legal representative, including a member of the claimant's immediate family.

(5) "Days" means calendar days.

(6) "Documentation" includes, but is not limited to, all written and electronic communication records, transactions, notes, work papers, claim forms, and explanation of benefits forms relative to the claim.

(7) "Investigation" means all activities of an insurer related to the determination of liabilities under coverages afforded by an insurance policy or insurance contract.

(8) "Notice of Loss" means any notification, whether in writing or other means acceptable under the terms of an insurance policy to an insurer or its representative, by a claimant, which reasonably apprises the insurer of the facts pertinent to a claim.

(9) "Proof of Loss" means written proofs, such as claim forms, medical authorizations or other reasonable evidence of the claim that is ordinarily required of all claimants submitting

claims.

R590-191-4. Minimum Standards for Prompt, Fair and Equitable Claim Handling Processes and Communications.

(1) Notice of loss to an insurer, if required, shall be considered timely if made according to the

terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312.

(2) Notice of loss may be given to the insurer or its representative unless the insurer clearly directs otherwise in accordance with policy provisions or in a separate written notice mailed or delivered to the claimant.

(3) Subject to policy provisions, a requirement of any notice of loss may be waived by an authorized representative of the insurer.

(4) Insurance policies may not require notice of loss to be given in a manner which is inconsistent with the actual practice of the insurer. For example, if the practice of the insurer is to accept notice of loss by telephone, the policy shall reflect that practice, and not require that the claimant furnish "immediate written notice" of loss.

(5) Within 15 days of receipt of notice of loss from a claimant, the insurer shall provide necessary claim forms, instructions, and reasonable assistance so the claimant can properly comply with company requirements for filing a claim.

(6) Proof of loss to an insurer, if required, shall be considered timely if made according to the terms of the policy, subject to the definitions and provisions of this rule, and the provisions of Section 31A-21-312. Proof of loss requirements may not be unreasonable and should consider all of the circumstances surrounding a given claim.

(7) Within 15 days of receipt of proof of loss from a claimant, the insurer shall:

(a) provide written acknowledgment of the receipt of the proof of loss;

(b) request any necessary additional information from claimant; and

(c) commence any necessary investigation of the claim, including requesting additional information from other parties having documentation or information relating to the claim; or

(d) provide the claim settlement and a written explanation of benefits to the claimant if no additional information or investigation is necessary.

(8) Within 15 days of receipt of any communications relating to a claim which reasonably suggests that a response is expected, the insurer shall substantively respond to such communication.

(9) Within 30 days of receipt of proof of loss from the claimant, the insurer shall complete the investigation of a claim, unless such investigation cannot reasonably be completed within such time. It shall be the burden of the insurer to establish, by adequate records, that the investigation could not be completed within 30 days of its receipt of proof of loss. If the investigation cannot be completed within 30 days, the insurer shall communicate to the claimant a written explanation as to the reasons for the delay and shall continue to so communicate at least every 30 days until the claim is either settled or denied.

(10) Within 15 days of completion of the investigation, the insurer shall either:

(a) provide the claim settlement and a written explanation of benefits to the claimant; or

(b) provide, in writing, a denial of the claim and an explanation to the claimant as to the reasons for the denial.

(11) Closing a claim file without settlement is considered a denial and must be so communicated in writing to the claimant and according to the provisions of the policy.

(12) If recalculation/revisitation of a claim becomes necessary subsequent to either denial or settlement, the insurer shall again comply with the initial claim handling process requirements as described in this section.

(13) Upon receipt of an inquiry from the Insurance Department regarding a claim, every licensee shall furnish a substantive response to the Insurance Department within the time period specified in the inquiry.

R590-191-5. Unfair Claims Settlement Practices.

The commissioner, pursuant to 31A-26-303(4), hereby finds the following acts or failure to perform required acts to be misleading, deceptive, unfairly discriminatory, or overreaching in the

settlement of claims:

(1) concealing from or failing to fully disclose to a claimant any benefits, limitations, exclusions, coverages, or other relevant provisions of an insurance policy or insurance contract under which a claim is presented;

(2) denying or threatening the denial of a claim for any reason which is not clearly described in the policy;

(3) refusing to settle claims without conducting a reasonable and complete investigation;

(4) refusing to provide a written basis for the denial of a claim upon demand of the claimant;

(5) failing to provide the claimant with a written explanation of the evidence of any investigation or file materials giving rise to the denial of a claim based on misrepresentation or fraud on an insurance application, when such misrepresentation is the basis for the denial;

(6) compensating employees, agents or contractors of any amounts which are based on savings to the insurer as a result of reducing or denying claims;

(7) making a claim settlement to the claimant not accompanied by a statement or explanation of benefits setting forth the coverage under which the settlement is being made and how the settlement amount was calculated;

(8) failing to settle a claim following receipt of proof of loss when liability is reasonably clear in order to influence other claim settlements under other portions of the insurance policy coverage or under other policies of insurance;

(9) advising a claimant not to obtain the services of an attorney or other advocate or suggesting the claimant will receive less money if an attorney is used to pursue or advise on the merits of a claim;

(10) misleading a claimant as to the applicable statute of limitations;

(11) issuing a check or draft in partial settlement of a loss or a claim under a specified coverage when such check or draft contains language which purports to release the insurer from total liability;

(12) failing to pay interest at the legal rate, as provided in Title 15 of the Utah Code upon amounts that are overdue under these rules. A claim shall be considered overdue if not settled within 15 days of completion of the investigation; and

(13) failing to deliver a copy of the insurer's guidelines for prompt investigation of claims to the Insurance Department when requested to do so.

R590-191-6. File and Record Documentation.

Each insurer's claim files for policies or certificates are subject to examination by the commissioner of insurance or by the commissioner's duly appointed designees. To aid in such examination:

(1) The insurer shall maintain accessible and retrievable claim file data for examination. The insurer shall be able to provide the policy number, certificate number if any, duplicate of the policy as issued, date of loss, date notice of loss was received, date proof of loss was received, date any investigation commenced, date the investigation was completed, date of settlement or denial of the claim or date the claim was closed without settlement, documentation as to how the claim was settled and how any payments were calculated, and any other documentation relied upon for claim settlement by the insurer. This data shall be available for all open and closed files for at least the most recent three year period, or, for a Utah domiciled insurer, since the date of the previous examination by the department, whichever is longer.

(2) Detailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim.

(3) Each document within the claim file shall be noted as to date received, date processed or date mailed.

(4) The claim file records must be maintained either in hard copy files, or some other format that has the capability of duplication to hard copy.

R590-191-7. Severability.

If any provision or clause of this rule or its application to any person or situation is held invalid, such invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

KEY: insurance law
1999

31A-2-201
31A-2-204
31A-2-308
31A-21-312
31A-26-301
31A-26-303

[Back to Top]